HS-88-038-AK
6-1800-1943-2

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE MINNESOTA DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Revocation and Non-Renewal of the Foster Care License of Irene Koering

FINDINGS OF FACT, CONCLUSIONS, RECOMMENDATION, AND MEMORANDUM

The above-entitled matter came on for hearing before Allan W. Klein, Administrative Law Judge, on December 15, 1987, in Minneapolis. The record closed at the end of the hearing on that date.

Appearing on behalf of Hennepin County was John St. Marie, Assistant Hennepin County Attorney, A-2000 Government Center, Minneapolis, Minnesota 55487. Appearing on behalf of Irene Koering, the Licensee herein, was Thomas Bennett Wilson III, Attorney at Law, 3940 West 49-1/2 Street, Edina, Minnesota 55424.

Notice is hereby given that, pursuant to Minn. Stat. sec. 14.61 the final decision of the Commissioner of Human Services shall not be made until this Report has been made available to the parties to the proceeding for at least ten days, and an opportunity has been afforded to each party adversely affected to file exceptions and present argument to the Commissioner Exceptions to this Report, if any, shall be filed with Commissioner Sandra S. Gardebring, Second Floor Space Center Building, 444 Lafayette Road, St. Paul, Minnesota 55101.

STATEMENT OF ISSUE

Should the family foster care license of Irene Koering be revoked or not renewed because of an incident of alleged neglect which occurred in the course of a medical emergency?

Based upon all of the proceedings herein, the Administrative Law Judge makes the following:

FINDINGS OF FACT

1. Irene Koering (hereinafter "Koering" or Respondent") has been a licensed foster parent since June of 1978, a period of roughly ten years. Her home is located on Bloomington Avenue in Richfield.

2. During the ten years of licensure, she has cared for approximately 60 children and one adult. Twenty of these children were permanent placements (relatively long term), while 40 were shelter placements (relatively short term). She is currently licensed for five children, but had applied for

additional licensure for one specified adult (a 21-year-old woman who has been living with her for some time).

3. Up to three years ago, all of Koering's permanent placements were emotionally disturbed children. In the last few years, however, most of her placements have been mentally retarded or mentally handicapped children.

4. On an average over the last three years, Respondent would have four mentally handicapped children. These would include two ambulatory, and two non-ambulatory.

5. Respondent has taken far more than the minimum required number of training courses. She has spoken at informational meetings designed to solicit new foster care parents, she has appeared in a video tape cassette on teenage discipline, and she has taught classes for single foster parents.

6. At the present time, Respondent is caring for two children and one adult. The adult is 21 years old, and Respondent made an application for a license to allow this one adult to stay at her home pending the adult's long-term placement in another facility where she is on a waiting list. This adult has Down's Syndrome, and a full scale IQ of 56. She has resided with Koering since July of 1985. Her social worker determined that continuing the placement at the Koering foster home would be beneficial pending the outcome of this appeal process and a final decision regarding the adult care license.
Ex. 7.

7. Stephanie W. is a two-year-old girl. She is multi-handicapped. She has no ability to speak or otherwise communicate except on the most basic level (smile and cry). She can receive stimulation only from her sense of sound and sense of touch, as she is blind. She is also mentally retarded. She is fed through a tube in her stomach, rather than eating through her mouth.

8. By June of 1987, Stephanie W.'s stomach tube was permanently inserted into the side of her midsection, at approximately navel level, but off to one side. It extended out from her body approximately ten inches. It was clamped off. Stephanie could ingest only liquids through the tube. In June of 1987, Stephanie weighed approximately 19 pounds.

9. On June 3, 1987, at approximately 11:15 a.m., Irene Koering received a telephone call from Stephanie's day program, AccessAbility, Inc. This is located in North Minneapolis. The telephone call was to inform Respondent that the tube in Stephanie's stomach was half in and half out, and that

Stephanie needed immediate medical attention.

10. At the time of the telephone call, Ms. Koering had two children in her care at home -- Randy W., a seven-month-old boy, and Rachel K., a six and one-half year old girl.

11. Respondent's preferred medical provider for Stephanie's stomach tube was Dr. David Rustad. After receiving the telephone call from Stephanie's day program, Respondent called Dr. Rustad's office to see if he would be available. She was told by a secretary there that he was not in the office, but that he was at Children's Hospital (Minneapolis Children's Medical Center) in South Minneapolis. The doctor's secretary informed Respondent that he would be at the hospital until 12:40 p.m., and that if Respondent could get

Stephanie to the hospital by that time, Dr. Rustad would see her in the emergency room. The secretary indicated that she would call Dr. Rustad at the hospital to alert him that Ms. Koering would be bringing Stephanie in.

12. Ms. Koering attempted to contact her back-up people to see if they could watch Randy and Rachel while she took Stephanie to the emergency room. She tried four people, none of whom could be reached. She determined to take Randy and Rachel with her. She bundled them up, and set out to pick up Stephanie.

13. When she arrived at the North Minneapolis day program, Respondent discovered that Stephanie was screaming and exhibiting great pain. Stephanie calmed down if she were laying flat, and so Respondent carried Stephanie in a prone position, across her extended arms, out to the van. Respondent felt it was necessary for Stephanie to be in a car seat during the ride to the hospital, and so she placed her in one. Stephanie resumed her loud screaming. Respondent had only seen Stephanie behave this way once before, which was another incident where her tube had come out.

14. Respondent then drove to the Children's Medical Center. She had been there several times before, both with her own biological children and with foster children, but she had never before been to the emergency room there. She located a parking space near an entrance, and parked the van. Despite the screaming, Randy was asleep in his car seat. The radio had been playing music. Respondent decided to allow Randy and Rachel to stay in the car while she went to the emergency' room with Stephanie. She instructed Rachel to stay in the van with Randy. She left the key in the ignition so the radio would play. She left the doors unlocked. Rachel is not mentally handicapped, but she is emotionally disturbed. She had been with Respondent for a little more than two years. She was capable of appropriate behavior.

15. Randy, the seven-month-old, was born very prematurely. It is believed that he is a likely candidate for apnea, but he has never actually had any incidents of breathing cessation. Nonetheless, he has been connected to an apnea monitor for at least as long as he has been at Respondent's home. The monitor itself is a box, approximately eight inches by eight inches, weighing around six pounds. It is usually powered by ordinary AC current, but it contains a rechargeable battery which is supposedly good for 12 hours of operation. Respondent, her two children, and her sister had all been trained in the use of the apnea monitor and in CPR technique in case Randy should ever need help.

16. The monitor indicates a problem in either breathing or heart rate by emitting an audible beeping sound at a relatively high volume. Persons in the Koering home have all been told that should the monitor ever begin beeping, they are to locate Ms. Koering at once. One time the monitor did go off and Rachel got Ms. Koering from a shower stall in the bathroom to alert her that the alarm had gone off. The only times that the alarm has gone off have always been a result of a malfunction of the unit.

17. Respondent arrived at the Children's Medical Center between 12:15 and 12:20. She entered the building, carrying Stephanie in her arms. She asked where the emergency room was, and was told that it was at the other end of the building. She had entered near the admissions area, not the emergency area. She then proceeded down to the emergency room, where she announced herself and

the purpose for her visit. She was informed that before anything could be done for Stephanie, she would have to be admitted through the admissions area. Respondent was frustrated and upset, because she believed that the time was much closer to the 12:40 deadline than it actually was. She turned around, and went back to the admissions area. There is at least half a block's distance between the two areas. She carried Stephanie with her.

18. Respondent walked past the admissions desk and went outside to her van. She looked in the back window of the van and observed that Randy was awake and laughing, and that Rachel was playing with him. She did not tap on the window or otherwise advise them that she was there.

19. Respondent went back into the Medical Center, and registered Stephanie. Her registration was "clocked" as having occurred at 12:25 p.m. Respondent then proceeded, still carrying Stephanie, back to the emergency room. She then informed personnel on duty that she had two children waiting in a car, that one of them was on a monitor, and that it was imperative that she see Dr. Rustad promptly. She was informed that Dr. Rustad was not there, and must be somewhere else in the hospital. Respondent waited while a nurse went to look for the doctor. The nurse returned, indicating that she did not find him. A few minutes later, Respondent again repeated her request, and the nurse again went to look for the doctor, with the same results. Respondent asked the nurse if there was parking closer to the emergency room, and the nurse informed her that there was not. It was while they were discussing parking that Respondent heard her name being called over the public address system.

20. Approximately ten minutes after Respondent had registered, and after she had left the admissions area to go back to the emergency room with Stephanie, Rachel appeared in the admissions area asking for help with the baby in the van because the apnea monitor had begun to beep. Medical personnel were called to the van at 12:38 p.m., and attended to Randy. They determined that the cause of the beeping was a battery problem with the monitor, not a medical problem. Security personnel questioned Rachel about who was in charge. Rachel indicated that she did not know where her foster mother had gone, nor could she tell them her mother's complete name. A security guard noticed a handicapped sticker with the name "Irene Koering" on it, and had Koering paged over the hospitals public address system. At some point during this process, the heart monitor began to beep again, and a life support unit was called to the van. The life support unit and Respondent both arrived at the van at approximately 1:02 p.m.

21. Respondent, upon hearing her name over the public address system,

went to the emergency room desk, where she was told to respond by telephone. On the telephone, she was connected with the admissions area. She was informed of the problem with the heart monitor. She she asked if somebody could watch Stephanie while she dealt with this new problem. Both the admissions area person and an individual in the emergency room agreed to watch
Stephanie. Stephanie was then left in their care while Respondent went out to
the van to see what was wrong with Randy.

22. The life support unit on Randy was checked, and it was determined that he was fine (apart from being upset by all the activity) and that the problem was with the monitor's battery pack.

23. Upon determining that Randy was all right, the security guard confronted Respondent about leaving the infant and a six-year-old unattended. She replied that she had believed her visit to the emergency room was only going to take a minute. The security guard later reported that her demeanor was matter of fact, and that she did not seem upset or concerned.

24. Respondent got in the van, drove it around to the other end of the hospital, located a parking space reasonably close to the emergency room, put Randy in a stroller and, carrying the monitor, took Randy and Rachel inside to the emergency room where they all waited for the doctor to appear. After some additional wait, Stephanie was seen and treated by another doctor (not Dr. Rustad). The procedure to reinsert the tube took only a couple of minutes, and the group left the hospital at 1:30 p.m.

25. On that same day, a report of the incident was made to the Child Protection Division. The division responded promptly, requesting a written complaint and organizing an informational meeting for the next day, June 4. Pursuant to routine procedures for these kinds of complaints, a variety of personnel participated in the informational meeting -- licensing workers, case management workers, child protection investigators and other county officials. Those that could not attend were asked for input by telephone. one of the placing social workers noted that one of his clients placed at the home had graduated from high school on the afternoon of June 3, and that Ms. Koering had arrived late for the graduation. She expressed frustration at being late for the graduation, explaining that she had had to wait an hour to see a doctor when taking another foster child to the emergency room. However, she did not mention anything to him about the incident of the other foster children having been left in the van. Following a thorough discussion of facts and impressions about the foster home, the Child Protection Unit determined to investigate the matter further because they feared that a child (Randy) had been placed at risk of possible injury by Koering's conduct of leaving him in the car unattended.

26. The Child Protection Unit conducted a thorough investigation of the matter, speaking with numerous personnel at the hospital, the doctor's office, and others. On July 10, a Child Protection worker made an unannounced visit on Ms. Koering, accompanied by Koering's licensing worker, to interview her about the incident. Ms. Koering was forthright, and gave the impression of not being surprised to see an investigator involved in the matter. The only substantial deviations between the events as described by Respondent to the investigator and the events as the investigator pieced them together from speaking with others were, (1) the time of arrival at the hospital (Respondent thought it was much closer to the 12:40 deadline than the 12:15 to 12:20 actual arrival time, (2) whether or not Respondent had been there in the past

(Respondent claimed she had never been to the emergency room before, whereas a nurse informed the investigator that Respondent had taken Stephanie there twice before), and (3) whether or not Respondent's foster-daughter, Rachel, had been instructed to "keep the whole thing a secret", which the investigator determined was a possible cover-up. In light of the tremendous amount of factual detail involved, these discrepancies are neither surprising nor shocking. Each of them was discussed at length at the hearing. They are resolved as follows:

a. Respondent must have arrived at the hospital between 12:15 and 12:20. The clock in her van is fast. That factor, plus the stress of

having Stephanie screaming and trying to get from North Minneapolis to South Minneapolis before the 12:40 deadline, account for Respondent's belief that she arrived at the hospital much later than she actually did.

b. Respondent has not been to the emergency room at Children's Medical Center in the past. She has picked up Stephanie at the Medical Center, and visited her there while Stephanie was an in-patient, but she has not been to the emergency room itself. Stephanie's prior visits to the emergency room were with her biological mother, not Respondent.

C. Respondent did tell Rachel not to discuss the incident with students or teachers at school. Rachel had a habit of discussing all manner of family matters at school, a practice which disturbed Respondent. Respondent attempted to tell Rachel that it was all right to talk with her social worker and others, but Respondent doubts whether Rachel understood the distinction. It is found that Respondent did not attempt to have Rachel 'cover up" the incident from responsible authorities.

27. On July 23, 1987, the Child Protection Unit completed an 11-page report. The report acknowledged the extenuating circumstances of Respondent's being concerned about the well-being of Stephanie, whom she believed to be in great distress, but nevertheless concluded that leaving Randy and Rachel unsupervised in an unlocked vehicle with the keys in the ignition constituted substantiated neglect.

28. Shortly thereafter, on August 6, 1987, the licensing social worker who handled the Koering home, and his supervisors, prepared a memo to the Hennepin County foster care team. The gist of the memo was to set forth some additional information which had been gathered since the June 23 report, and to request that Koering be granted a waiver from a rule which would otherwise prohibit the renewal of her license, or the issuance of the adult care license which was then pending, because someone in the household had substantiated evidence of child neglect.

29. Among the new evidence discovered between July 23 and August 6 was that Respondent had been to the Medical Center before, but not to the emergency room. Secondly, it was discovered that Respondent had looked into the van between the time that she came from the emergency room to the admissions area and her actually registering at the admissions area. Thirdly, after returning to the emergency room, Respondent had twice told the nurse that she had a baby on a monitor in the car, and needed to see the doctor immediately. Finally, Respondent was confronted with the allegation that she had attempted to have her daughter, Rachel, "cover-up" the incident. Respondent satisfactorily explained that she had not done so, and further explained that she knew very well that there would be an investigation as a result of the incident. Each of these has been accepted by the Administrative Law Judge.

30. Attached to the request for waiver was a proposed contract. The contract would be between Koering and the licensing worker, and would place

limitations upon the number and types of children which Koering could have in the home. Ex. 3. The request for waiver was submitted to the Department of Human Services, which has not formally acted on it. However, the Department orally directed the County to prepare a recommendation for revocation, thus implicitly denying the requested waiver.

31. On September 28, 1987, the State Department of Human Services issued a Notice of and Order for Hearing, setting the hearing in the matter for December 15. It was served upon Respondent and her attorney by mailing on November 9, 1987.

32. Respondent's foster care license was scheduled to expire, routinely, on May 1, 1987. For reasons having nothing to do with this incident, an extension was granted to June 30, 1987 to complete the renewal process. The renewal, and the granting of the adult license for one adult, are both "on hold" pending the outcome of this proceeding.

33. Respondent has never had any serious allegations raised about the conduct of her facility in the ten years that she has operated it. At one point, there was a concern about sexual interaction between two young women at the facility, but it was determined that there was no neglect on Respondent's part. County personnel talked with her, and it was determined to change the bedroom arrangements, separating the two. It was suggested at the hearing, but not proven one way or the other, that in fact it was Respondent who brought the matter to the attention of County authorities, seeking their advice.

34. It continues to be the recommendation of both the licensing social worker and his supervisor that probation is more appropriate than revocation. They recommend that, for a limited period of time, the number of persons allowed in the home be reduced, from five children to three children and one adult. They continue to recommend that future placements include no more than one non-ambulatory client at a time. They continue to recommend that there be a qualified caretaker supervising the children at all times.

35. It is very difficult to find permanent placements for children such as Stephanie W., Randy, Rachel, and many of the other children whom Respondent has cared for. There is a serious shortage of placement alternatives for such children. Respondent has learned how to care for such children, and has developed the skills to do so. Her present licensing worker has complete confidence in her abilities. Her prior licensing worker was shocked to hear of the proposed revocation. Even after hearing the facts of the incident, she would not have any hesitancy in having Respondent continue to be licensed because "she's one of the best homes we have".

36. A licensed consulting psychologist who had a client placed in Respondent's home testified that it takes a great deal of patience and willingness to learn and understand new techniques needed to deal with mentally retarded children. She would have no reservations about having any

of her clients continue to live there or go to live there. She was asked if she felt that Respondent had neglected her client, and she responded: "To the contrary, she is highly committed and has done an excellent job. She's more than a good technician.' She went on to opine that it would be contrary to the best interests of her client to have her removed from Respondent's care. Her client has had several foster placements, and each has had problems requiring a change. Her client has exhibited severe behavior problems every time there has been a move. Her client has been with Respondent now for two to three years and they are well adjusted to each other. It was the psychologist's professional opinion that if the client were removed from Respondent's care, it was likely that extreme behavior problems would again occur, and the progress which has been made might be undone.

37. A senior social worker who has a client at Respondent's facility observed that Respondent has been very patient with her client's acting out and that her client's behavior has very much improved since being at Respondent's home. If Respondent continues to be licensed, the social worker would have no concerns about her client remaining at Respondent's facility. Her client had been in four foster homes, and that this is the longest placement so far. She stated it's hard to find someone who would invest the amount of time that Respondent has invested in her client.

38. A registered nurse from the Minneapolis Children's Medical Center reported on the consistent concern which had been shown over Randy's potential apnea. The nurse indicated that she had no reservations about the care that Respondent has provided to Randy, characterizing Respondent as very capable and loving.

39. A medical doctor from the Richfield Pediatric Clinic who also treated Randy indicated that he was impressed by Respondent's dedication and concern for Randy's well-being.

40. A senior social worker who has a client at Respondent's facility indicated that he hoped his client could remain in the home during the appeal process and during the time the final decision is made regarding the license. He assessed his client's placement in the facility as "beneficial', stating that Respondent had followed through fully on the social service plan and cooperated with him in arranging various appointments for the client. His client's behavior, physical appearance and independence have improved during her stay with Respondent.

41. On September 23, 1987, the social worker for Rachel and her sister, Angie, wrote a letter to Respondent, describing their current status. They had left Respondent's care after the incident, but not as a result of the incident. They had left because they were able to move home, which was part of their case work plan. The social worker wrote Respondent:

> . . . to let you know how much your work with Angie & Rachel is appreciated. They gained a great sense of what expectations are reasonable in a "normal family", both of discipline and pleasures . . . . Your work laid the foundation in their minds for a different view of family, and taught them how to function in a more healthy setting. Give yourself a hug.

PERTINENT STATUTORY AND RULE EXCERPTS

Minn. Stat. sec. 626.556 (1986) defines "neglect" to mean:

> Failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter or medical care when reasonably able to do so or failure to protect a child from conditions or actions which imminently and seriously endanger the child's physical or mental health when reasonably able to do so.

Minn. Rule pt. 9545.0090 provides that a foster family home license:

> shall not be issued or renewed where any person . . . living in the household has any of the following characteristics:

(1) a conviction of, or admission of, or substantial evidence of an act of assault, or child battering, or child abuse, or child molesting, or child neglect;

Minn. Rule pt. 9545.0190, subp. 4, provides that, "Children in care shall be adequately supervised at all times.'

Minn. Rule pt. 9545.0020, subp. 14, provides that failure to comply with parts 9545.0010 to 9545.0260 shall be cause for denial, nonrenewal, or revocation of a license.

Based on the foregoing Findings, the Administrative Law Judge makes the following:

CONCLUSIONS

1. The Administrative Law Judge and the Commissioner of the Department of Human Services have jurisdiction over this matter pursuant to Minn. Stat. SS 245.781 to 245.812 (1986) and, to the extent necessary to vest continuing jurisdiction, Minn. Stat. SS 245A.01 to 245A.16 (1987).

2. The appropriate statutory standard to use in evaluating the conduct at issue here is the standard in effect at the time of the incident, namely, Minn. Stat. SS 245.781 to 245.812 (1986). This was the statutory provision cited in the Notice of and Order for Hearing, and it was the version in effect at the time of the incident. Respondent's Motion to Dismiss this proceeding because of an alleged failure to comply with certain provisions of Minn. Stat. ch. 245A (1987), is DENIED.

3. The appropriate definition of "child neglect" to be used in this proceeding is that contained in Minn. Stat. sec. 626.556, subd. 2(c) (1986). This section was agreed to by all parties and the Administrative Law Judge at the start of the hearing.

4. The actions of Irene Koering in leaving Rachel and Randy in the car while she took Stephanie into the emergency room, under all of the facts and circumstances which existed at the time of that incident, was not "neglect" within the meaning of Minn. Stat. sec. 626.556 (1986). See, Memorandum.

5. Respondent did violate Minn. Rule pt. 9545.0190, subp. 4 by failing to supervise the children "at all times". See, Memorandum.

6. The Commissioner has authority to make a license probationary. Minn. Stat. sec. 245.801, subd. 3 and 4 (1986). Under the new statute, the Commissioner may make a license probationary (section 245A.07, subd. 1 and subd. 3) and, in addition, may impose "special conditions of licensure" within the meaning of Minn. Stat. sec. 245A.04, subd. 7(6) (1987).

Based on the foregoing Conclusions, the Administrative Law Judge makes the following:

RECOMMENDATION

That the proposed revocation and nonrenewal of the foster case license of Irene Koering be DISMISSED, or,

IN THE ALTERNATIVE, it is recommended that Respondent's license be made probationary for a period of six months, during which time it is subject to revocation if Respondent fails to properly supervise children.

Dated this 4th day of January, 1988.

ALLAN W. KLEIN
Administrative Law Judge

NOTICE

Pursuant to Minn. Stat. sec. 14.62, subd. 1, the agency is required to serve its final decision upon each party and the Administrative Law Judge by first class mail.

Reported: Tape Recorded - 3 Tapes

MEMORANDUM

Irene Koering was faced with a difficult situation. Not one of her four back-up people could take care of the two children while she took Stephanie to the emergency room. Therefore, she had to take the two children with her.

Upon arrival at the hospital, Respondent parked the van and took Stephanie in. Respondent had hoped that she was at the emergency room door and that the doctor would be waiting for her. She knew from past experience that the reinsertion procedure was very fast. It was not physically possible for her to carry Stephanie so as to minimize her pain and to also carry Randy along with his monitor box. Based on these facts, she elected to leave Rachel and Randy in the van while she took Stephanie inside the hospital.

In hindsight, there were better ways that this could have been handled. Once Respondent realized that she was not at the emergency room, she could have requested that someone watch Stephanie while she went out and got Randy and Rachel and brought them in. Even when she got to the emergency room and was told she had to go back and register, she could have asked someone there to watch Stephanie while she went back, got the two children out of the van, and then registered. In hindsight, she could have done a better job of minimizing the time that the two children were exposed to the risk of being unattended.

The statute, however, does not require perfection from foster parents. Instead, it requires that they protect children from imminent and serious danger "when reasonably able to do so". What Irene Koering did, under the

circumstances as she perceived them, was reasonable. It was not perfect, but it was reasonable. Therefore, her actions did not constitute 'neglect".

The preferred disposition of this matter is total dismissal. However, should the Commissioner desire to discipline Respondent (more than she has

already been penalized) for her action, it would be appropriate to make her license probationary for some limited period of time. The mental stress and financial outlay which Respondent has already incurred as a result of this incident has, in my opinion, already made an impression on Respondent, and it is unlikely that she would make the same decisions again. Therefore, I believe it is unnecessary to make the license probationary.

A.W.K.